DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

APPLICATION FOR ADULT DAY CARE LICENSE

AGENCY NAME _____
Print

AGENCY ADDRESS _____
ADDRESS 1

_____
ADDRESS 2

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR _____
Print

PHONE NUMBERS _____ _____
AGENCY PHONE NUMBER AGENCY FAX NUMBER

AGENCY TYPE ☐ PRIVATE ☐ NOT FOR PROFIT
PLEASE CHECK ALL THAT APPLY
HOURS OF OPERATION:_____ ☐ PUBLIC ☐ PROPRIETARY

_____

CAPACITY:_____ ☐ OTHER:_____

ACCREDITED? ☐ YES ☐ NO

IF YES, NAME OF ACCREDITING ORGANIZATION AND ACCREDITATION EXPIRATION DATE:

_____
Print

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES AND ADDRESSES OF EACH OFFICER, DIRECTOR, AND OWNER HAVING FIVE (5) PERCENT OR MORE INTEREST IN THE AGENCY.
2. ACCREDITING AGENCY(IES) REPORT(S)
3. FIRE SAFETY REPORT
4. OTHER:_____

_____

DOES YOUR AGENCY PROVIDE NURSING SERVICES AS DEFINED IN SECTION 2.0 OF THE DELAWARE REGULATIONS FOR
ADULT DAY CARE FACILITIES? ☐ YES ☐ NO
IF YES, NAME AND LICENSE NUMBER OF SUPERVISING NURSE:

_____

Print

NAME & TITLE OF PERSON DESIGNATED TO ACT IN ABSENCE OF NURSING SUPERVISOR:

_____

Print

NAME OF PERSON COMPLETING THIS FORM:_____

Print

SIGNATURE:_____

TITLE:_____

DATE:_____

CHECKS SHOULD BE MADE PAYABLE TO: **DELAWARE DIVISION OF PUBLIC HEALTH**

INITIAL APPLICATION FEE:	ANNUAL LICENSURE FEE:
$100.00	$50.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE AND ATTACHMENTS TO
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
2055 LIMESTONE ROAD
SUITE 200
WILMINGTON DE 19808

12/05